DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445479	A. BUILDING 01 - LIFE CARE CENTER OF GRAY B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GRAY	791 OLD GRAY STATION ROAD GRAY, TN 37615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch The findings include: Observation and Interview with the Maintenance Director, on August 20, 2013 at 8:45 am confirmed corridor door to resident room 112 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.	K 018	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a) No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. a) All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Corridor door to resident room 112 immediately fixed to positive latch by adjusting hinges by Maintenance Director on 8/20/2013. Drill will be conducted once weekly for three months to ensure these doors close to a positive latch. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	10/05/2013
K 021	NFPA 101 LIFE SAFETY CODE STANDARD	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 9-6-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SEP 09 2013

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K 021 SS=E	Continued From page 1 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor fire doors would close to a positive latch. The findings include: Observation and Interview with the Maintenance Director, on August 20, 2013 at 10:40 a.m. confirmed the following corridor fire doors would not close to a positive latch: door to Physical Therapy near transient rehab room, Kitchen fire doors to the dining room, and corridor fire doors at the entrance to the dining room. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.	K 021	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Door to physical therapy near transitional rehab and corridor fire doors to the dining room immediately fixed to positive latch by adjusting hinges by Maintenance Director on 8/20/2013. Hinges replaced on kitchen fire doors on 9/3/13 and now close to a positive latch. Drill will be conducted once weekly for three months to ensure these doors close to a positive latch. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	10/05/2013

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K 029 K 029 SS=D	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on April 18, 2013 at 1:15 p.m. confirmed the Medical records storage room and the Staff Development office doors were not provided with door closers. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.	K 029 K 029	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Door closures installed on the medical record storage room and staff development office doors on 9/3/13. Doors will be spot checked once a week to ensure the closures remain functional. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	10/05/2013
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective	10/05/2013

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K 045	Continued From page 3 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure exits paths to the public way was provided with lighting. The findings include: Observation and interview with the Maintenance Director, on August 20, 2013 at 11:35 a.m. confirmed the outside lights at the side exits from station 400, rear of the building and front/side were not provided with egress lighting such that the failure of any single lighting fixture (bulb) would not leave the area in darkness (NFPA 101, 7.8.1.4). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.	K 045	action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Lights added at the side exits from station 4. Lights will be checked once weekly to ensure they are still functional for three months. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the sprinkler system was maintained. The findings include:	K 062	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? 2 sprinkler heads will be replaced to be quick response heads on 9/13/13 to ensure all three sprinkler heads outside the social services	10/05/2013

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K 062	Continued From page 4 1. Observation and interview with the maintenance director in the compartment outside the Social Services office, on August 20 at 8:50 a.m. confirmed only one (1) of three (3) sprinkler heads were quick response heads. 2. . Observation and interview with the Maintenance Director on August 20 at 1:50 p.m. confirmed wires supported by sprinkler piping in the attic by room 306 and above the laundry corridor. These findings were verified by the Maintenance Supervisor and acknowledged by the administrator during the exit conference on August 20, 2013.	K 062	office are quick response heads. Will check once weekly to verify these sprinkler heads are still in place for three months. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: NFPA 90A, 3-4.7 Maintenance - At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Based on observation, interview and record review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A. The findings include: Observation during the building tour on August 20, 2013 between 9:45 a.m. and 1:30 p.m.	K 067	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All fire dampers identified and labeled. 4 year required maintenance performed on all dampers. Dampers will be spot checked once weekly to ensure functionality for three months. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months.	10/05/2013

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K 067	Continued From page 5 confirmed over 30 fire dampers were observed. Record review and interview with the Maintenance Director on August 20, 2013 at 1:30 p.m. confirmed the facility performed the 4-year required maintenance to twelve (12) fire dampers. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.	K 067	The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All clutter removed from the laundry wing corridor. All staff educated not to store anything in this area. Maintenance director will check daily to ensure no objects are blocking the means of egress for three months. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the corridors in the means of egress were maintained clear of all obstructions (NFPA 101- 7.1.10.2.1.) The findings include: Observation and interview with the Maintenance Director, on August 20, 2013 at 1:50 p.m. confirmed the laundry wing corridor had clean linen carts, floor dollies, and boxes of resident personal belongings throughout the corridor. This finding was verified by the Maintenance Supervisor and acknowledged by the administrator during the exit conference on August 20, 2013.	K 072		10/05/2013